

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011594

STATE FILE NUMBER

317

Primary Registration District No.

541

Registrar's No.

680

MAR 10 1959

Registration District No.

300

-57

1. PLACE OF DEATH

a. COUNTY

ST LOUIS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MO

b. COUNTY

ST LOUIS

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

CLAYTON

Inside Limits
Yes ☒ No ☐

c. CITY
OR
TOWN

ST John 4211

Inside Limits
Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

ST LOUIS CO HOSPITAL

Length of stay in lb

2 WKS

d. STREET
ADDRESS

3521 MARSHALL

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Jeanette F

Fox

4. DATE
OF
DEATH

Month

Day

Year

3

12

1959

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ 2. DIVORCED ☐

8. DATE OF BIRTH

6-4-1868

9. AGE (In years
or birthday)

90

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

HOUSE WORK

10b. KIND OF BUSINESS OR
INDUSTRY

AT HOME

11. BIRTHPLACE (City and state or country)

ST LOUIS MO

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13a. FATHER'S NAME

HUGH WHITTLE

13b. MOTHER'S MAIDEN NAME

CAROLINE GILBRAITH

14. NAME OF HUSBAND OR WIFE

ALFRED FOX (DEAD)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

Address

A. H. Fox 3521 MARSHALL ST JOHN MO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest (operative, for duodenal ulcer)

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Probable Hypoxia

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

1. Acute hemorrhagic colitis

5410

INTERVAL BETWEEN
ONSET AND DEATH

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURY

Hour

a.m.

Month, Day, Year

p.m.

20d. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 3-4-1959 to 3-12-1959 and last saw her alive on 3-12-1959
Death occurred at 6:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

John E. Oakley, M.D.

22b. ADDRESS

601 S. Brentwood Blvd.

22c. DATE SIGNED

3/13/59

23a. BURIAL, CREMATION,
or other disposal (Specify)

23b. DATE

3-16-59

23c. NAME OF CEMETERY OR CREMATORY

Bellevue

23d. LOCATION (City, town, or county)

St Louis

(State)

MO

24. FUNERAL DIRECTOR

ADDRESS

Carl Helman, Ireland MO

25. DATE RECD. BY LOCAL REG.

3-14-59

26. REGISTRAR'S SIGNATURE

J. B. Murphy, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

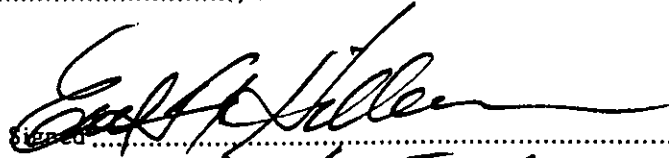
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 350/
P. O. Address Oueland, x 97

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.